Trust Board Paper O

To:	**Trust Board**
From:	Director of Marketing and Communications
Date:	**29th May 2014**
CQC regulation:	

Title:	**Caring for the Oldest Old**

Author/Responsible Director: Mark Wightman, Director of Marketing and Communications

Supported by: Heather Leatham, Dr Jay Banerjee, Dr Simon Conroy, Dr Kevin Harris, Lara Wealthall, Carole Ribbins and Rachel Overfield.

Purpose of the Report:
A Strategic Direction for Frail and Older People's Services at University Hospitals of Leicester NHS Trust.

The Report is provided to the Board for:

Decision		Discussion	X
Assurance		Endorsement	X

Summary / Key Points:

The NHS in its widest sense and for the purposes of this paper the acute sector specifically, need to recognise that frail older people are no longer a cohort of patients they are THE PATIENT and we should therefore act / plan accordingly. This is the proposed response from Leicester's Hospitals.

Recommendations:
The paper suggests a number of actions designed to…

1. Change culture and practice and recognise that we need to fundamentally up skill our staff to enable them to meet the needs of the oldest old.
2. Change our physical environment so that it is frailty friendly and understand that in doing so we are benefitting all patients.
3. Fix some of the basics which make caring for this cohort of patients harder or less effective.
4. Involve others in the design and planning of services for older people and involve carers in their care.
5. Position care of older people as core business by appointing an Executive and NED Board lead.
6. Create a brand which puts Leicester on the map and in doing so reassures our local population whilst attracting clinical talent and research funding.

… And seeks the Boards support for the strategy and its delivery through the establishment of an Older Peoples Strategy Board as part of 'Delivering Caring at its Best'.

Previously considered at another corporate UHL Committee? Endorsed by the Executive Strategy Board	
Board Assurance Framework: Safe, high quality, patient centred care.	**Performance KPIs year to date:** **To be decided**
Resource Implications (eg Financial, HR): To be determined	
Assurance Implications:	
Patient and Public Involvement (PPI) Implications: Data from patient surveys / feedback /complaints have informed the paper. Patient and carer representation on the Older People's Strategy Board will be essential.	
Stakeholder Engagement Implications: AGE UK (Leicester / Leicestershire) have been consulted and will continue to work with the Trust on this agenda.	
Equality Impact: We know that there are differences between cultures in their response to age and ageing… and as a consequence, different requirements and needs when it comes to the clinical care of older patients from different backgrounds. However, this is not a subject which has had much prominence locally or nationally and will therefore be an important component of the strategy / plan.	
Information exempt from Disclosure: NA	
Requirement for further review? Progress report in 6 months	

Trust Board 29 May 2014

Subject: A Strategic Direction for Frail and Older People's Services at University Hospitals of Leicester NHS Trust.

Title: "Caring for the Oldest Old"

Author: Mark Wightman, Director of Marketing and Communications.

Introduction:

There is no shortage of commentary or evidence that as a consequence of the changing demographic of our nation, there is an equivalent change required in the ways that both public and private sector services for older people are designed.

The subject of frailty and age is so all encompassing, even when it is just considered from an acute hospital's perspective, (where the only two services which are relatively untouched by the demographic changes are maternity and paediatrics), that it is impossible to create in one document a genuine frail older people's strategy which encompasses acute, social, primary, 3rd sector and mental health, care.

Instead, this paper focuses on some key themes, that can be considered to be within our own control and suggests either new or enhanced approaches which build on much of the good work which is already happening in different parts of the Trust. The fact that there are numerous initiatives already in train is a clear indication that many staff and staff groups recognise the importance of this subject. In that sense this Strategic Direction is also an attempt to 'package' existing work to create a unified approach to the care of older people. Finally whilst this paper has been put together by the DM&C the thinking has been largely influenced by discussions with colleagues, particularly, Heather Leatham, Dr Jay Banerjee, Dr Simon Conroy, Dr Kevin Harris, Lara Wealthall and Carole Ribbins and Rachel Overfield.

Definitions:

In discussions with colleagues and in the research underpinning this paper it is clear from the outset that there are cultural issues which impact on any discussion related to the care of frail older people. Foremost is the tendency to discuss the ageing population in pejorative terms, underpinned by the assumption that with age comes frailty. This is not the case. Self-reporting shows that the majority of people aged over 80 are satisfied or very satisfied with their health. (Oliver 2012, Discrimination in Health Services for Older People' International Journal of Medical Ethics).

'Frailty' and 'age' are clearly linked but the assumption that one has to be old to be frail overstates the case and misses the point that there are other causes of frailty. This is important both in terms of acknowledging that whilst our ageing population, undoubtedly

creates new challenges it is also an opportunity in terms of many people living longer, economically productive lives during which they contribute more than ever to the wealth of the nation. One only has to look at the number of older people pushing prams during school half terms to recognise that their contribution to wider society is often overlooked.
Indeed, even the term 'older' can be divisive because it begs the question, at what age does one become an older person? The phrase used by our own clinicians Dr Jay Banerjee and Dr Simon Conroy in their 'Silver Book', ('Quality Care for Older People with Urgent and Emergency Care Needs') is useful here… they refer to the 'oldest old' as those people most in need of a new approach from health services.

Therefore the key principle of this paper is that whilst it will most often link age and frailty, in terms of the patient population, the cohort of people it specifically centres upon is the 'oldest old'.

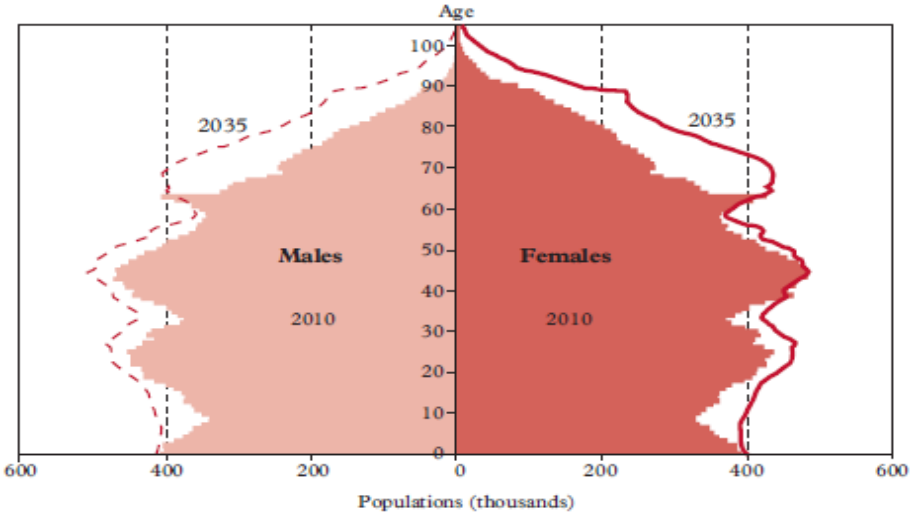
Context:
During the next 16 years we will see…

- 51% more people aged 65 and over in England in 2030 compared to 2010
- 101% more people aged 85 and over in England in 2030 compared to 20102
- Over 50% more people with three or more long-term conditions in England by 2018 compared to 2008
- Over 80% more people aged 65 and over with dementia (moderate or severe cognitive impairment) in England and Wales by 2030 compared to 2010.

(HOUSE OF LORDS Select Committee on Public Service and Demographic Change. Report of Session 2012–13 'Ready for Ageing?'**)**

The increased older population is shown in the 'Christmas tree' diagram (Figure 1) below, with the biggest increase in profile amongst those people aged 70-90.
Figure 1

Estimated and projected age structure of the United Kingdom population, mid-2010 and mid-2035[55]



Locally we are already seeing this impact. Recent reviews have told us that the age related illness has caused a dramatic shift in acuity in many of our inpatient wards and our own data shows that whilst A&E attendances are broadly stable, admission rates continue to increase.

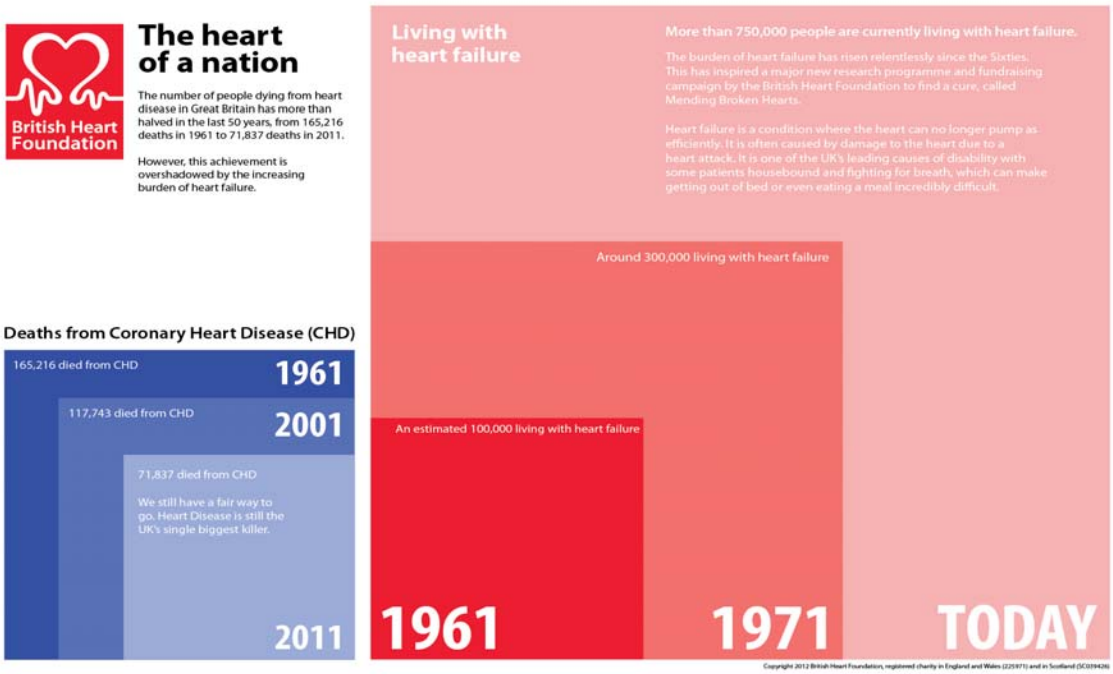
Figures released by the Health and Social Care Information Centre have shown that the number of people aged over 90 who have gone to hospital by ambulance has risen 81 per cent – up from 165,910 in 2009-10 to 300,370 last year.

As stated above an older population is not in itself a problem. The problems occur when the demographic changes are not matched by equivalent changes in service delivery.

Clinically, we know that for a cohort of older patients there is an increased likelihood that they will not only live for longer but will live with illness for longer and for the majority of patients it will not be a single long term condition they live with.

The graphic in Figure 2 (below) speaks to this point. Deaths from coronary heart disease have plummeted over the last 50 years both as result of lifestyle factors but also because surgeons and cardiologist are now able to routinely operate on a cohort of patients who until very recently would not have been able to withstand the hitherto invasive nature of a heart procedure. Now with the advances in technique and technology clinicians can fit new heart valves in a cath' lab, not an operating theatre, non-invasively, meaning that it is common for patients of 75 years and older to have years added to their lives and to be back on their feet within a couple of days.

Figure 3



However as a consequence and as the BHF graphic shows, there has been seven fold increase in those people now living with heart failure.

Again, by 2030…

- People with diabetes: up by over 45%
- People with arthritis, coronary heart disease, stroke: each up by over 50%
- People with dementia (moderate or severe cognitive impairment): up by
- over 80% to 1.96 million
- People with moderate or severe need for social care, up by 90%.

If we then overlay the fact that a majority of older, frail, co-morbid patients also have some kind of brain disease ranging from transitory delirium to dementia, we must ask ourselves… are we properly prepared?

The House of Lords Select Committee on ageing thinks not:

"The National Health Service will have to transform to deal with very large increases in demand for and costs of health and social care. Overall, the quality of healthcare for older people is not good enough now, and older people should be concerned about the quality of care that they may receive in the near future. England has an inappropriate model of health and social care to cope with a changing pattern of ill health from an ageing population".

And the Kings Fund agrees:

"The model of acute care is unsuited to patients with complex needs. The physical environment, working practices and care processes of acute hospitals geared to the model of acute medical care presuppose that the main task of the hospital is treatment and cure. However, care pathways and performance targets for waiting times and access to elective procedures are either irrelevant or actively obstructive to high-quality care for patients with complex conditions".

(KINGS FUND "The care of frail older people with complex needs: time for a revolution". Author: Jocelyn Cornwell March 2012)

Overall the diagnosis appears to be that the NHS in its widest sense and for the purposes of this paper the acute sector specifically, need to recognise that frail older people are no longer a cohort of patients they are THE PATIENT and we should therefore act / plan accordingly.

The rest of this paper looks at some of the specific challenges we face as a result of the context described above and proposes a number of actions to address these challenges.

Challenges and suggested actions

Culture & leadership:

The cultural and language aspects of caring for older people are deeply ingrained. First, at a societal level we recognise that this country's approach to older members of our society differs significantly from that of say, the southern European countries. Moreover in the national discourse around older people's care, phrases like 'perfect storm', 'bed blockers' and 'financial burden' all contribute to the mind-set that older people with health issues are a problem as opposed to a natural consequence of advances in medicine and public health, which could, if we chose to, be celebrated.

The cultural element is also present within the health service itself. The Kings Fund states that, 'Older people's services do not have high societal status and are not generally considered attractive options for professionals'… meaning that there is a shortage of a doctors willing to specialise in geriatric medicine and a perception amongst some staff that the care of older people is somehow less clinically meaningful than for example, nursing in certain surgical specialities.

The reality is that for those who have chosen to specialise in the medical care of older people and for those nursing older people, the job is rewarding whilst, especially for nurse colleagues, tremendously demanding, largely as a result of the historical link between nurse staffing levels and 'acuity' which takes little account of the unique demands placed upon those nursing the oldest old who can often be confused and wandering.

The time is right in a post Francis world to reposition care of older people, especially for nurses, in a way that recognises that it requires levels of compassion, skill and technical ability *at least* equivalent to those healthcare professionals who specialise in paediatric care. The Kings Fund report already referenced above says, "We need to see a revolution in the education and training of current and future staff so that staff are equipped to care for the majority of the patients they are there to serve."

ACTIONS:

1. *We should consider creating a new nursing qualification for those caring for the oldest old.* The cohort of nurses who are supported to seek this qualification will be the 'best of the best', specifically those are already showing the caring and technical skills they will require to become masters in their field of expertise. Ideally the qualification will be co-created with partners at DeMontfort University, and we should explore the potential for central funding for a pilot cohort. Crucially, we must 'brand' these nurses in such a way that once qualified they, stand out in the eyes of their peers, the patients and the public. (Red Uniforms). Given the changes in demography and the required changes in the health services these nurses will ultimately be the Nurse Directors / Chief Nurses of the future… recruited for values and ability and prepared to meet the demands of the NHS in 5-10 years' time.

2. The Trust has previously had a board level Director of Services for Older People, (DSOP). Due to changes in personnel the position was lost when the post holder

changed roles. We should look at this again. However, this time around rather than creating a Director and accompanying directorate, (which has since morphed into the Patient Experience Team) we should look to simply having *a named Director and Non- Executive Director* who have, as a key priority within their portfolio the task of consistently testing / questioning Board decisions in line with this strategy and the ultimate goal described in the Summary / Vision below.

Clinical Specialism:

The rise of clinical specialisms over the years has clearly brought many benefits to patients. However, the role of the specialist is to diagnose, treat and cure in their field of expertise. In the care of the oldest old there is no 'cure' for ageing and as such it requires a different approach and mind set from the clinicians involved in their care. On a number of occasions when researching this paper people mentioned that when it came to the care of the oldest old (especially those with multiple long term conditions), "The consultants did their bit according to their specialism but nobody seemed to be in overall charge of my…" (Father in law / Dad / Mum etc).

As we know increasingly, (outside of paediatrics and obstetrics), the 'average' patient is becoming older and frailer. The current response to this conundrum in most health economies is to hire more geriatricians to work alongside their colleagues as part of the MDT, offering a more holistic view of care plans. However, as a result of the shortage of geriatricians there are more posts than people. This is likely to continue and is linked in part to the cultural aspects of caring for older people discussed above.

ACTIONS:

1. *Improve the trust's ability to recruit and retain geriatricians*, see section on 'brand' below.
2. *Consider the creation of non medical consultant posts specialising in care of older people, (nurse consultants).*
3. *Consider an approach to 'core' training for clinicians which incorporates a module based on care for the 'oldest old'*. In other words if we recognise that care of the oldest old is increasingly likely to be a component of the clinical care of most of our patients, then rather than rely on older people's specialists to compliment the decision making of say a cardiologists, we seek to up skill / educate our other specialists to become more competent in the care of older people. Whether or not this would eventually become a 'mandatory' training module is for discussion but we should perhaps consider that what defines mandatory is at least in part, a result of what is most commonly / urgently required for all clinicians to know.

4. *Consider how we best co-ordinate the care of the oldest old recognising that those with co-morbidities will often cross services and specialities. For example, the creation of a post of patient specific 'care co-ordinator'* within hospital. These people would be tasked with the 'choreography' of care across different disciplines and specialisms.

Fostering research and innovation in the care of older people:

A consistent theme in feedback from colleagues is that when we compare care of older people as a specialism with other clinical specialisms the related research and innovation activities seem relatively underdeveloped.

Whilst many of the strongest research areas in the trust focus on older people with multi-morbidity and/or cancer, the activities are commonly defined by disease area, and the context of the older person is often not emphasised. Currently in UHL there are many examples of care pathway re-design and clinical service developments focused on older people and frailty. Many of these clinical service developments in the care of older people are innovative in themselves, and may be amenable to academic study and evaluation. Therefore we need to increase the profile of research and innovation activities involving older people whilst at the same time creating an environment where the activities can grow and flourish. We need to provide our talented clinical teams with the tools required to initiate and complete research projects involving this group of people and help them obtain funding if required. Furthermore we need to take the opportunity presented by implementation of service changes to facilitate academic evaluation of novel clinical services, and where appropriate disseminate our experiences to the wider health community, especially recognising that there are distinct cultural differences to ageing in the communities we serve.

ACTIONS:

1. Explore with our partners at the University of Leicester the development of an academic post to support research and innovation in the care of older people.
2. The UHL R&D office will provide a 'horizon scanning' function to bring research opportunities to the attention of our researchers in a timely manner.
3. We will support the development within UHL of an Improvement Science and Innovation Unit. This will provide a structure to allow the academic evaluation of service change and ensure that we do not miss opportunities for learning and dissemination.

Environment and facilities:

Patients with frailty and dementia, or other kind of brain diseases require a purpose built or at the very least an adapted environment if they are to feel at their safest, most comfortable and well oriented.

Our children's wards, clinics and A&E are tailored to the requirements of young people in recognition that they are small, fragile, scared, not always able to communicate and of course, ill. We would never contemplate treating a child on an adult ward but we routinely treat older people with similar needs in compromised environments.

Clearly, with over 100 wards across the Trust the notion that we can either afford or continue to operate effectively whilst redesigning them for frailty is beyond us. However, if

we start from the position that our aspiration is to make all appropriate wards frailty friendly over a timescale of say, 10 years, then we might be able to achieve our aspiration with judicious use of capital and even a contribution from a charitable funds campaign.

Action:

1. *Form a task and finish group consisting of nurse / clinician / facilities and PPI to scope and establish what a frailty friendly ward would look like*. (Signage, social space, flooring, acoustics, lighting, bed side furniture etc). This work will be influenced by the information that we already have from the 'Quality Mark for Elder Friendly Wards' scheme. Calculate the cost per ward and work with finance and charitable funds colleagues to devise a programme for implementation.

<u>The first 'Frailty Friendly' A&E :</u>

The rise in attendances and subsequent rise in admissions to adult ED from those people aged over 65 is well known. We have already committed to building a new A&E and Emergency Floor and within that commitment is the desire to create England's first 'frailty friendly' A&E.

However, as there is no current blueprint for what such a facility would look like from a patient or clinical perspective it will be both necessary and an opportunity for the Trust to create the NHS 'industry standard' model for a bespoke emergency / urgent care environment for the oldest old. There is also an opportunity to think about this in terms of brand and potential beneficial endorsement of our new A&E. Specifically, the Trust has built good relations with partners in AGE UK locally and we are already working on a plan to bring an AGE UK advice shop into the Royal Infirmary. There is the potential, if AGE UK colleagues are included in design discussions early enough, for us to seek a unique partnership for the 'UK's first Frailty Friendly ED in association with AGE UK.'

ACTIONS:

1. Form a task and finish group consisting of nurse / clinician / facilities and PPI to scope and establish what a frailty friendly A&E would look like. (Signage, social space, flooring, acoustics, lighting, bed side furniture etc).

2. *Seek agreement in principle for AGE UK endorsement of Leicester's new A&E* subject to necessary assurances and involvement in the design blueprint.

3. Explore the possibility of *securing national funding* (or at the very least national recognition) that the Leicester way is a THE beacon for best practice.

<u>Fixing the basics:</u>

There are some recurrent themes when speaking to nurses or reading patient feedback and complaints which we might class as 'basics'.

For example, we know that hospitals are confusing and often frightening places for older people. Especially for those with dementia or delirium. Just imagine how much more confusing the environment becomes when a hearing aid or patients glasses are lost. Visual

and auditory functions already compromised by age can reduce, meaning that a smile and some reassuring words from the care team are lost on the patient.

Other 'basics' which come up all too often are things like meal portion sizes for older people,(little and often as opposed to 3 x 3 courses a day which can be daunting to people more used to 'grazing').
Patient moves and outlying, especially if this happens in the small hours, which just adds to feelings of confusion and disorientation; standard issue low trolleys which are easier for staff and patients alike to use.

ACTION:

1. *Hold a Listening into Action style event with staff, carers, partners and patients to look at some of the basics and quick wins*. Then take this feedback and commit to addressing the issues within a defined period, (12 months).

<u>Involvement of carers:</u>

In other parts of this paper the comparisons between how we care for the oldest old and some of our youngest patients are discussed in the sense that they share many similar vulnerabilities but do not benefit from the same bespoke approach to service design.

In paediatrics we would not consider carrying out ward rounds without the parents of sick children being present but we do routinely carry out ward rounds without involving an older persons carer.

Research shows that of those older patients who have carers approximately 25% of them are spouses and in the main they are co-habiting with the patient when well. 50% of carers are sons or daughters. The point is that in many cases the carers have unique and rich information about an older persons 'normal' state and as such they are hyper aware of anything 'abnormal'.

How many times have we heard in the media that, "I knew something was wrong with mum, she was going downhill fast but I couldn't get anyone to listen."?

For example, an invented but nonetheless representative scenario; an older patient admitted with a Urinary Tract Infection, who as a result, is at a heightened risk of delirium, which is often mistaken for dementia because the symptoms (acute confusion) are uncannily similar whilst the treatment is vastly different. In this example the carer is crucial to a fast and accurate diagnosis i.e. if they are able to describe their spouse or parent as generally functioning without impairment in their normal state and therefore unusually confused at the time of admission… or subsequent to admission, the nurses and doctors are more able to diagnose effectively.

ACTIONS:

1. We should consider how we can more effectively *use information from carers to improve the quality of care for the oldest of the old.* This might be by inviting carers to take part in a ward based review of the patients progress, and / or…
2. *Invite carers to construct a pen portrait of their relative* which would be included in the patients notes. The point being that if healthcare professionals can appreciate what the person was like before the current symptoms and the current almost inevitable look of vulnerability, they might have a better understanding of what a 'return to form' would look like. For example…

"Mrs MW is 83. Before her admission to hospital she lived alone, was devoted to her small dog, Sally and was active socially, she still maintains and runs her own car. Her hearing and eyesight is good.
She was occasionally unsteady on her feet but showed no signs of confusion.
Before retirement she was a policewoman in the Rutland Constabulary and a radiographer at the Royal Infirmary."

<u>Brand:</u>

As we build upon the Trust's Strategic Direction and start to devise business plans for our Clinical Management Groups we will inevitably begin to discuss brand and specifically how we might differentiate our potential brands to compete for patients and for nurse and clinician talent. 'The East Midlands Heart Centre' / 'The Leicester Respiratory Centre' / 'The Leicester Cancer Centre in Association with CRUK' are all on the table and ripe for marketing, assuming that we can show that there is a return on investment in attracting patients regionally and nationally.

In terms of market positioning there is plenty of competition in many of our specialist markets.

However, thus far no Trust in the country has sought to position itself as excellent in the care of older people. The reason for doing so would be different compared to that of our tertiary markets. We would not be seeking to attract more patients, if anything the opposite would be true BUT in terms of attracting talent and research funding, positioning the Trust as the NHS leader in the care of older people would be attractive. In fact given the predicted growth in this population the premise that caring for the oldest old is beginning to look like our core business, one might ask why wouldn't we seek to make the 'Leicester way' a brand in its own right?

ACTIONS:

1. Given that the integrity / success of a brand is based entirely on whether the product or service it relates to is effective, then the only action is really to decide whether we want to enact some or all of this strategic direction for older people. If we do, then we have the underpinnings of a brand.

Delivering this strategy:

The new 'Delivering Caring at its Best', (DC@iB) project structure will include a dedicated multi-disciplinary board which will drive the Older People's strategy. The board will bring together clinicians, nurses, AHPs under the leadership of the Chief Nurse and Director of Marketing & Communications. The task of the board is twofold first to take each of the strands of this strategy and create the plan to enact them; second to join up the various elements of the Trust's existing work on the care of older people to avoid duplication and to focus attention on the actions which will have the most material benefit for patients.

ACTIONS:

1. Establish the older peoples strategy board, with due consideration to the right clinical input and the patient / carer voice and create the project initiation document, (PID) to plan and execute the strategy.

Summary / vision:

As stated in the introduction this paper does not set out THE strategy for care of the 'oldest old' in Leicester's hospitals. Instead it seeks to propose a strategic direction with examples of actions to be taken and ideas to explore or mainstream in response to some of the current challenges. There is lots of good work already in train, (Dementia champions, Meaningful Activities Co-ordinators etc).

It is also recognised that this paper is silent on matters of integration across primary, social and mental health care. This is not to downplay the pressing need for such services and clinical pathways to be more systematically 'joined up' but is rather, a reflection that those discussions are best held between clinical teams across the various partner agencies.

In talking to the doctors and nurses with specialist knowledge of caring for the oldest old, the consistent theme is that if a hospital designs services, environments and care pathways with this cohort of patients in mind, then ALL patients benefit.

With this in mind the 'lift pitch' for this paper is:

The NHS needs to focus on the care of the oldest old. As far as Leicester's Hospitals are concerned we are already seeing the impact of demographic changes. If we recognise this and think about the requirements of patients who are old and frail we must necessarily see that there is much we could do to improve. This will require us to…

1. Change culture and practice and recognise that we need to fundamentally up skill our staff to enable them to meet the needs of the oldest old.
2. Change our physical environment so that it is frailty friendly and understand that in doing so we are benefitting all patients.
3. Fix some of the basics which simply make caring for this cohort of patients harder or less effective.
4. Involve others in the design and planning of services for older people and involve carers in their care.
5. Position care of older people as core business by appointing an Executive and NED Board lead.

6. Create a brand which puts Leicester on the map and in doing so reassures our local population whilst attracting clinical talent and research funding.

Recommendations:

The Board are invited to discuss the contents of this paper; endorse / support the strategic direction and remit the Older People's Strategy Board to carry this work forward with progress being reported in 6 months.

ENDS

REFERENCES:

HOUSE OF LORDS Select Committee on Public Service and Demographic Change. Report of Session 2012–13 'Ready for Ageing?'

KINGS FUND "The care of frail older people with complex needs: time for a revolution". Author: Jocelyn Cornwell March 2012

The Silver Book, "Quality Care For Older People With Urgent and Emergency Care Needs." Authors Dr J Baneerjee Dr Simon Conroy. 2010

Health and Social Care information Centre, Accident and Emergency Attendances in England - 2012-13 Publication date: January 28, 2014

Oliver 2012, "Discrimination in Health Services for Older People" International Journal of Medical Ethics